# CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

## CALIFORNIA MEDICAL ASSOCIATION†

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SAM J. McCLENDON, M.D.....President-Elect
E. VINCENT ASKEY, M.D.....Speaker
LEWIS A. ALESEN, M.D.....Vice-Speaker
PHILIP K. GILMAN, M.D.....Council Chairman
JOHN W. CLINE, M.D...Chairman, Executive Committee
GEORGE H. KRESS, M.D..Secretary-Treasurer and Editor
JOHN HUNTON .....Executive Secretary

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† For complete roster of officers, see advertising pages 2, 4, and 6.

## OFFICIAL NOTICES

### EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

*Minutes of the One Hundred Ninety-third (193d) Meeting of the Executive Committee of the California Medical Association*

The one hundred ninety-third (193d) meeting of the C.M.A. Executive Committee is recorded as a vote-by-mail meeting, the decisions having been reached by telephone intercommunication on June 8, 1945, with subsequent ratification of minutes by mail by Doctors Gilman, McClendon, Askey and Cline.

1. **Roll Call of Voting Members:**

President and Council Chairman Philip K. Gilman; President-Elect Sam J. McClendon, Speaker E. Vincent Askey, John W. Cline, Chairman of the Auditing Committee.

2. **Concerning Senate Bill 1306:**

Dr. John W. Cline, after conference with President Gilman authorized Dr. Gilman to telephone to President-Elect Sam J. McClendon and Speaker E. Vincent Askey, relative to request submitted by the Chairman of the C.M.A. Committee on Public Policy and Legislation, Dr. Dwight H. Murray of Napa, concerning Senate Bill 1306. S.B. 1306, introduced on June 2, 1945, by State Senator Arthur H. Breed of Oakland, contained provisions that could make for complications in the development of medical service plans in California.

After exchange of opinion the four members of the C.M.A. Executive Committee unanimously agreed that the C.M.A. Committee on Public Policy and Legislation should be instructed to oppose S.B. 1306, and President Philip K. Gilman and Messrs. John Hunton and Howard Hassard were delegated to oppose S.B. 1305 at the Senate Committee hearing on Monday, June 11, 1945.

JOHN W. CLINE, M.D.,
*Chairman, C.M.A. Executive Committee,*
GEORGE H. KRESS, M.D.,
*Secretary, C.M.A. Executive Committee.*

*Minutes of the One Hundred Ninety-fourth (194th) Meeting of the Executive Committee of the California Medical Association*

The 194th meeting of the C.M.A. Executive Committee is recorded as a vote-by-mail meeting, decisions having been reached by telephone intercommunication on Tuesday, June 24, 1945, with subsequent approval of minutes by mail vote of Doctors Gilman, McClendon, Askey and Cline.

1. **Roll Call of Voting Members:**

Philip K. Gilman, President and Chairman of the Council; Sam J. McClendon, President-Elect; E. Vincent Askey, Speaker, and John W. Cline, Chairman.

2. **Proposal to Establish a Nevada Physicians' Service:**

The conference was held to present a report upon a meeting held with members of the Nevada State Medical Association. A plan was discussed whereby a Nevada

Physicians' Service would be established in the State of Nevada, the same to begin its work as a regional group to be administered (temporarily as such), through California Physicians' Service.

3. **Action Taken:**

In order to make possible the institution of the plan whereby another voluntary prepayment group would come into operation through coöperation with its constituent State medical association, at the request of California Physicians' Service, the Executive Committee, voted that the California Medical Association loan to California Physicians' Service the sum of $300.00 per month, for a period not longer than twelve (12) months (if necessary), to place Nevada Physicians' Service on a working foundation.

Further, the said loan from the C.M.A. to C.P.S. to be repaid by California Physicians' Service within a period of some thirty-six (36) months after the completion of the aforesaid loan.

JOHN W. CLINE, M.D.,
*Chairman, C.M.A. Executive Committee,*
GEORGE H. KRESS, M.D.,
*Secretary, C.M.A. Executive Committee.*

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### Proposed Amendment to C.M.A. Constitution Re: Ex-officio Members of Council

*For action taken on this resolution, see below.*

*Be It Resolved,* That the first paragraph of Section 1, Article VII, of the Constitution of the California Medical Association be amended to read:

"The Council shall consist of the Councilors, and ex-officio: The President, the President-elect, the Speaker and Vice-Speaker of the House of Delegates, each with all the rights of a Councilor."

and, be it

*Resolved,* That the first paragraph of Section 4, Article X of the Constitution of the California Medical Association be amended to read:

"The President, President-elect, the Speaker and Vice-Speaker of the House of Delegates shall be ex-officio members of the Council with all the rights of Councilors."

SPEAKER ASKEY: This is an Amendment to the Constitution and By-Laws and must lie on the table for one year and must be published twice during the year in the *Official Journal.* It is so referred to the Association Secretary to be laid on the table and published as required by the By-Laws.

(For reference in minutes of House of Delegates, see June CALIFORNIA AND WESTERN MEDICINE, page 327.)

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## COUNTY SOCIETIES†

### CHANGES IN MEMBERSHIP

**New Members (16)**

*Alameda County* (1)
Siebert, Alfred A., *Oakland*

*Contra Costa County* (2)
Dunphy, John, *Richmond*
Loewenstein, Edith, *Pittsburg*

*Fresno County* (3)
Freeto, F. R., *Fresno*
Nelson, George A., *Fresno*
Tostenson, Norman E., *Fresno*

*Humboldt County* (1)
Reicher, Jacob, *Eureka*

*Sacramento County* (2)
Carter, Kenneth L., *Sacramento*
Kassis, John, *Sacramento*

*San Diego County* (3)
Peters, Lindsay, *San Diego*
Sargent, Willard Snow, *San Diego*
Shea, Paul A., *San Diego*

*Santa Clara County* (3)
Ahnlund, Nels W., *San Jose*
Bellinger, S. B., *Agnew*
Cleveland, Luella S., *San Jose*

*Tulare County* (1)
Brady, R. F., *Visalia*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

## In Memoriam

**Brown, Beaumont.** Died at Sacramento, July 2, 1945, age 68. Graduate of the College of Physicians and Surgeons of San Francisco, 1904. Licensed in California in 1924. Doctor Brown was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.

✤

**Cochran, George Vrooman.** Died at Oakland, July 2, 1945, age 48. Graduate of the University of California Medical School, Berkeley-San Francisco, 1931. Licensed in California in 1931. Doctor Cochran was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

**Craig, Stephen Adelbert.** Died at Ontario, June 26, 1945, age 52. Graduate of the College of Physicians and Surgeons, Los Angeles, 1919. Licensed in California in 1920. Doctor Craig was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

**Fesca, Helmut William.** (First Lieutenant, United States Army.) Killed in action in Germany, July 27, 1944, age 27. Graduate of the University of California Medical School, Berkeley-San Francisco, 1943. Licensed in California in 1943. Doctor Fesca was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

**Green, Martin Icove.** Died at San Francisco, June 30, 1945, age 46. Graduate of the College of Physicians and Surgeons of San Francisco, 1921. Licensed in California in 1921. Doctor Green was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

**Inman, Jesse Headen.** Died at Bakersfield, July 15, 1945, age 44. Graduate of the University of California Medical School, Berkeley-San Francisco, 1929. Licensed in California in 1929. Doctor Inman was a member of the Kern County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

**Krout, Boyd Merrill.** Died at Stockton, May 4, 1945, age 60. Graduate of Harvard Medical School, Boston, Massachusetts, 1913. Licensed in California in 1919. Doctor Krout was a member of the San Joaquin County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

**Phillips, Charles Eaton.** Died at Los Angeles, June 15, 1945, age 65. Graduate of the University of Illinois College of Medicine, Chicago, 1903. Licensed in California in 1912. Doctor Phillips was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

**Strong, Kenneth Clark.** Died at Inglewood, July 3, 1945, age 42. Graduate of Stanford University School of Medicine, Stanford University-San Francisco, 1932. Licensed in California in 1932. Doctor Strong was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

**Tully, John James.** Died at Stockton, June 4, 1945, age 83. Graduate of the Cooper Medical College, San Francisco, 1886. Licensed in California in 1886. Doctor Tully was a Retired member of the San Joaquin County Medical Society, and the California Medical Association.

## OBITUARY

### Charles Eaton Phillips

### 1877—1945

Charles Eaton Phillips, in practice in Los Angeles from 1914, passed away on Friday, June 15, 1945. A native of Millington, Illinois, and a graduate of the Medical School of the University of Illinois in 1903, Doctor Phillips served in the Panama Canal Zone during the period 1906 to 1913, beginning as an intern in the Ancon Hospital and advancing until he became chief of the surgical clinic in the Colon Hospital. During World War I he was a major in the Medical Corps of the United States Army, being stationed at Camp Dodge in Iowa, and the Walter Reed Hospital in Washington.

In his affiliations in Los Angeles he was prominently identified with the development of the surgical work in the Los Angeles County General Hospital, where for some twenty-four years he was a surgeon on the Senior Surgical Service. He was a member of the attending staffs of practically all the major hospitals in Los Angeles.

A much beloved member of the medical profession, and a strong supporter of scientific and organized medicine, his death brought sorrow to a host of patients, friends and colleagues.

A special committee of the Los Angeles County Medical Association paid tribute to his memory in the following words:

To Doctor Phillips death came merely to deepen the restful sleep of a tired man, "just tired out" by a lifetime of service in the medical profession; eight years as surgeon in Panama when the Canal was built, a quarter century as chief surgeon at the Los Angeles County General Hospital, as writer on medical and allied subjects, as teacher in wards and medical school, as originator and adapter of surgical techniques which made him famous among his colleagues, and above all as a general surgeon practicing his art with skill, understanding and sympathy.

He was universally respected, admired and esteemed by the medical profession for his keenness of judgment, clarity of thought, and ability to meet difficult surgical emergencies by skillful use of trained hands and a thinking brain; by the general public for his unceasing thought for the well-being of patients in distress and pain.

He hated sham, half-truths and cynicism. In his writing his sharp wit and analytical probing brought revealing light into dark corners. His great surgical knowledge and his ability to talk understandingly brought him into law courts many times as an expert, relied on for his honesty and judicial judgment.

Among his colleagues he was loved and respected as few men are.

# CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

### Anniversary of the Army Medical Department

The Army Medical Department celebrated its 170th anniversary on July 27 of this year with the realization that it had grown into the largest organization of the kind ever known and that it is giving this nation's army the best medical care that soldiers have ever received.

From its inception in 1775 shortly after General George Washington became Commander-in-Chief of the Continental Army until the present day, the Army Medical Department has made steady progress in military medicine; it has made scientific discoveries that have benefited all of mankind; but never has its progress in both of these categories been so rapid as in recent years.

The Honorable Robert P. Patterson, Under Secretary of War, in a tribute to the work being done by the Medical Department under Major General Norman T. Kirk, The Surgeon General, recently said that no army at any time in history has achieved a record of recovery from wounds and freedom from disease comparable to that of the American Army in this war. Mr. Patterson said also that the Medical Department is attaining new records in almost every field of its endeavor. He cited the Army's record of saving nearly 97 of every 100 wounded soldiers who reach Army Hospitals, the disease rate of less than one in one thousand, and similarly startling figures with reference to malaria, the dysenteries, and other diseases, showing that the Medical Department has established effective control on all disease fronts. . . .

As an illustration of the remarkable advance of medical science in this war over other wars Major General Norman T. Kirk, The Surgeon General, recently cited the fact that in the Civil War the armies of the Union and Confederacy lost 336,216 men from disease; in World War I, deaths from disease totaled 62,670; but the rate in this war is only .6 of one man per 1,000 men per annum—or 12,000 deaths from disease since the war started.

### Major Craighill Reports on Health of Army Women Overseas

Major Margaret Craighill, MC, Consultant to The Surgeon General for Women's Health and Welfare, returned to Washington, D. C., this month from an eight-month inspection trip of WAC and medical installations during which she covered approximately 56,000 miles of the war zones. . . .

Major Craighill stated that in general the health of Army women overseas is excellent—even better than that of the men in many places because they have been given

a better break in living conditions. She found that illnesses are more prevalent among the older women and that the younger women are better able to adapt themselves to hardships and inconveniences. For this reason she expressed her personal opinion that women over thirty-five should not be sent overseas unless they were needed for top administrative posts.

There is no need to be concerned about the effect of either cold or tropical climates on American women, she said, although she believes that they should not be left in difficult climates overseas for more than two years.

Major Craighill, who was the first woman to be commissioned in the Army Medical Corps, was formerly dean of Woman's Medical College of Pennsylvania, Pa.

### President Truman Signs Bonus Bill for Medical Personnel

President Truman on July 7 signed legislation giving non-combatant Army Medical Corps personnel serving in the front lines the same $10 a month bonus paid to combat infantrymen.

The War Department previously awarded front-line Medical Corps men a badge similar to that provided expert infantrymen who are entitled to the extra $10 a month.

### "Sulfa" in Wounds Discontinued

The Army's accumulated experience in wound management does not justify the local use of any chemical agent in a wound as an anti-bacterial agent, according to the Office of The Surgeon General. The local use of crystalline sulfonamides (sulfa powder) has therefore been discontinued except in the case of serious cavities where its use, while permissible under the direction of the surgeon, is not recommended. This subject is covered by War Department Circular No. 160 as amended by W.D. Circular No. 176, 1945.

### Health of Troops in U.S.A. Is Excellent

During this past winter and spring the health of troops stationed in the United States has been excellent, surpassing that of any previous war year. The low hospital admission rate for all diseases reflects fewer communicable conditions, as it is during this period of the year that infectious diseases usually predominate.

There were less respiratory diseases than in any previous war year, although during May there was a slight rise in these cases. Pneumonia, measles, scarlet fever, meningitis, and rheumatic fever were all less prevalent than during the winter and spring of 1944. The only important infectious diseases of which this was not true were venereal diseases and infectious hepatitis.

Relapses in the United States of malaria infections acquired in tropical areas overseas increased each month until March, 1945, but have since declined slightly. With malaria control in all overseas areas now greatly improved, the number of relapse cases should continue to decrease.

The fact that most of our troops are well seasoned and there are fewer newly inducted troops is responsible in part for this improved health record. Most Army hospital beds here are now occupied by patients evacuated from overseas.

### President Truman Told More Doctors Are Needed for Postwar Period

Shortly after conferring with President Truman, a special committee of the Committee on Postwar Medical Service of the American Medical Association sent a memorandum to the chief executive, pointing to the country's failure to "provide for the training of enough physicians to meet the demands for doctors which we know will increase after the war."

The memorandum, mailed to the President recently and published in full in the July 21 issue of *The Journal of the American Medical Association*, was prepared by four physicians — Evarts Graham, St. Louis; Harvey Stone, Baltimore, and Victor Johnson and Fred C. Zapffe, both of Chicago.

The memorandum said in part:

"Even if admissions, enrollments and graduations from our medical schools should continue at the present wartime levels, only about half of this need would be met, since 40 000 students will receive the M.D. degree in the period 1942 to 1948 and 24,000 physicians will have died during that time. Thus, under the most favorable conditions only about 16,000 additional physicians will be available after the war to do the work of 30,000.

"In spite of this, freshmen enrollments in the medical schools of this country will be drastically reduced within the next year. In the past year virtually no able bodied males have been permitted to commence the two year course of college premedical studies because the Army and Navy have ceased assigning men to such studies and the Selective Service System has discontinued deferments of premedical students. In the past few years each freshman class of about 6,000 students included 4,000 to 5,000 able bodied men. These are no longer available under existing regulations.

"This deficiency can be corrected under the present Selective Service Act as follows: Defer qualified men now in college premedical studies when they reach 18 and defer 8,000 selected high school students of this year to commence college studies in premedicine. From these, 4,500 should be earmarked for admission to specific medical schools a year later. Repetition of this procedure each year the war lasts would effect the training of enough doctors to care for the health of the people. Consideration might also be given to the assignment of a limited number of men now under arms back to premedical studies, provided they pursued such studies satisfactorily before induction, as far as this may be consistent with military necessity."

### Army to Free 7,000 Doctors by May, 1946

The Army promised on July 11 to reduce its doctors by 7,000 by May, 1946—a rate of demobilization that was criticized by a Senate subcommittee as too low.

Plans for releasing doctors were disclosed at the committee's hearing on the relative needs of the civilian population and the Army for medical care.

Senator Johnson (D., Colo.) said "the leisurely attitude of the Army toward this problem is something that this committee ought not to accept lying down."

Brigadier General Robert W. Berry, representing the War Department took exception "to the use of the word leisurely," but Johnson reiterated he thought it was "the right word."

"There is a tragic and critical need for these doctors in our communities," put in Senator Downey (D., Calif.), subcommittee chairman.

Testimony brought out that the Army now has about 45,000 doctors and that, including those in the Navy and the Veterans' Administration, the total serving the armed forces is approximately 60,000.

In active civilian practice, by comparison, were roughly 74,000 doctors, although another 20,000 are in salaried jobs with State hospitals and industrial plants, or are serving as interns.

Berry told the committee the Army death rate from

sickness was six-tenths of a man per 1,000 a year, adding this is "the finest record any Army in any war ever attained." With fewer doctors, he said, "deaths would have skyrocketed."—San Francisco *Chronicle*, July 12.

### 900 Doctors Released by Army, but—

Senator Downey (D., Calif.) on July 18, stated that, while the Army may have released 900 medical officers since January 1, 1945, as it recently announced, it has taken in 1,500 others in that time.

"Thus there are more medical officers on duty now (in the Army) than were in January, 1945, despite the defeat of Germany," Downey asserted.

Downey, chairman of a military affairs subcommittee investigating use of the Army's medical personnel, said in a statement that he had been informed the released officers fall into five categories:

(1) Officers incapacited for any real work; (2) those dismissed after court-martial; (3) officers permitted to resign in lieu of being reclassified; (4) officers released for personal hardships "in many instances so severe as to prevent the individual from doing much work in private practice;" (5) some 50 to 100 individuals released so that they can minister to civilians.—San Francisco *Chronicle*, July 19.

## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

### The Doctors' Voluntary Health Plan for Nation

Now the physicians of the nation have advanced their own voluntary health insurance plan.

It frankly is an effort to forestall government action for socialization of medicine.

The success of the physicians' own proposals undoubtedly will depend in large measure upon the thoroughness with which they push their program. They must remember that vigor is required. The public must be convinced that voluntary health insurance is better than regimentation.

And it must not be forgotten that socialized medicine is being advocated most vigorously by certain political elements who continually are conducting an all-out campaign for regimentation of this entire nation. These elements will not rest a minute. They have some sincere converts to their belief, but many of them are motivated by selfish aims.

The American Medical Association, therefore, not only must prove that its 14-point program is adequate but also must be on guard against the highly glamorized counter-propositions from political sources. The public easily can be confused on this vital issue and possibly induced to believe that a State or Federal program of medicine would be preferable to a voluntary one.

The A.M.A. rightly adopts the traditional American principle of local intiative in its suggestions for hospitalization and sickness insurance. Its insistence that these insurance plans be of a local nature will assure the type best adapted to each locality. That would be one of the great difficulties in any State or Federal sickness insurance plan—trying to adapt it to crowded cities and sparsely populated rural areas under some inflexible overall plan. We saw the evils of such attempted administration in the days of depression relief under the New Deal.

Many local plans of health insurance already have proved highly successful. They undoubtedly can be improved upon as they are extended and more experience is gained. They will tend to retain the traditional personalized relationship of family doctor and patient.

Another advantage of voluntary local plans is that the people who actually are to benefit share the cost. Under certain governmental plans the taxpayer would be saddled with a burden which would not provide equal benefits. In other words, governmental plans probably would impose upon a member of some private group—who already was protected with health insurance—the same cost as upon his neighbor who had no such protection.

The doctors take note of the indigent problem by recommending local insurance plans in addition to the present county hospital setups and the like.

Now the lines have been drawn.

The Family Physician vs. the Government Doctor.

In the final analysis the public must make its choice.—Editorial in Los Angeles *Times*, July 28.

### Health Insurance Problems in U. S. Given Scientific Study

*Research Men Report Lack of Specific Information to Determine Exact Need For Medical Care*

Compulsory health insurance with all its broad ramifications is reviewed in the July 21 issue of *The Journal of the American Medical Association* which says, editorially, that it "is offered as a report of a scientific investigation into the forces now promoting the mechanism for medical service incorporated in the Wagner-Murray-Dingell bill."

*The Journal's* article, prepared by Carl W. Strow and Gerhard Hirschfeld, Research Consultant and Director, respectively, of the Research Council for Economic Security, sheds light on various national health problems in order that a better view might be obtained on the subject of compulsory health insurance. . . .

Strow and Hirschfeld emphasize in *The Journal* article the need for careful deliberation, both by the government and various states, with regard to current or contemplated proposals for compulsory health insurance. . . .

The authors state that during the legislative sessions of 1945, more than thirty measures proposing cash sickness benefit plans or compulsory health insurance systems were introduced in 12 state legislatures. Other bills called for studies of health insurance, and in Congress a number of bills were introduced providing for some sort of medical care or sickness benefits.

"The demand for compulsory health insurance," the authors said, "has been more consistent and more pronounced in some states than in others. New York, for instance, has had no fewer than 27 health insurance bills introduced in the legislature between 1935 and 1945. Yet New York has far better medical and hospital facilities, as well as provision for social services, than the average state. On the other hand, such states as Mississippi, Georgia, Alabama, Arkansas and the Carolinas, where the need for medical care is most acute, have practically no organized demand for compulsory health insurance."

"Since 1935 and including 1945," *The Journal* article said, "102 bills have been introduced into the legislatures of 20 states, with success only in Rhode Island, in 1942. The passage of the National Social Security Act in 1935 was largely responsible for the increased activity."

The two research men said it was difficult to form an exact conclusion on what the public thinks of the problem of health insurance.

"Public opinion polls would indicate that the public favors health insurance," they said, but added cautiously: "However, this depends on the form in which the question is submitted. If it emphasizes benefits, public opinion favors health insurance. But when the question emphasizes the financial cost, the necessary tax burden and the economic consequence in general, the public seems to be less sure about the desirability of a compulsory system.

"Notwithstanding the large amount of voluntary protection against illness, there is no disagreement among the advocates of compulsory health insurance, as well as the opponents, as to the need for better medical care. The disagreement is about the form, the administration, coverage, benefits and many other details. . . .

"The health problem differs in virtually every state. In California, communicable diseases account for a major share of reported illnesses. In Mississippi influenza, syphilis, malaria, gonorrhea and dysentery are high on the list of reported illnesses. In New York cancer, syphilis, tuberculosis and pneumonia are the important health problems. . . .

In conclusion, the researchers said:

"The demand for compulsory health insurance is promoted most powerfully by organized collective action, especially by organized labor. . . . Apparently, the opportunity to organize the demand is more important than the prevalence of the need for medical care. The evidence points to the probability that, contrary to popular belief, the legislative proposals for compulsory health insurance are based not so much on social needs as on political interests, and that the ability on the part of labor to organize and press the demand, rather than the concern about the state of health, is the primary consideration. . . .

"Illness apparently is not chiefly responsible for the demand for compulsory health insurance. If it were, recommendations would start in the medically least progressive states. However, they originate at the opposite end of the scale, where medical care and social services are most highly developed."

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## Proposed Health Bill by Kaiser

*Voluntary Plan Would Operate Through FHA*

Henry Kaiser has prepared a bill for introduction in Congress by Senator Claude Pepper (D., Fla.), that would permit establishment of voluntary systems for prepaid medical care throughout the country through the facilities of the Federal Housing Agency.

This was disclosed to the San Francisco Chronicle on July 18 with the information that the measure is about to be introduced as an amendment to the National Housing Act.

The bill is an outgrowth of Kaiser's experience in providing group health insurance to 125,000 employees monthly through the Kaiser Permanente Foundation.

### Talk With Senators

Kaiser recently conferred with Senators Pepper, Murray (D., Mont.), Hill (D., Ala.) and Taft (R., Ohio) at an executive subcommittee session, he revealed after Chronicle inquiry, and "their questions indicated they had no serious objections to the plan."

The measure provides:

1. Guaranteed local bank loans to groups interested in setting up facilities for prepaid medical care.

(Under this provision a group of physicians, or a nonprofit organization limited to labor, management and labor-management groups, or states and political subdivisions, could obtain a 90 per cent loan on a hospital property for group medicine.)

2. Technical assistance to the F.H.A. by the U. S. Public Health Service in determining the need and likelihood of success of the individual project.

3. Limitations upon the F.H.A. administrator, barring him from exercising any supervision or control over the administration, personnel or operation of the facilities except where specifically provided by law.

4. Preference for utilizing existing private or public facilities, and preference—in case two applicants seek to establish a medical facility in the same area—of the more complete plan.

### Typical Case

As explained by Kaiser, a typical case might be as follows:

"Suppose ten service doctors who had learned to work together wanted to continue their work in private life. Each of them might have $2500—they could borrow that much under veterans legislation.

"They pool their $25,000 and use it as the down payment on a guaranteed loan on a hospital property, say a 60-bed hospital capable of serving a population of 10,000. They give the F.H.A. a 4½ per cent mortgage on the hospital property.

"Then they go, for example, to ten manufacturers or merchants employing a thousand people each. These employers agree to deduct 10 cents a day from the pay check of employees who subscribe to the plan.

"Ten cents a day from 10,000 subscribers is a thousand dollars a day income, or $365,000 a year. This should supply the doctors' and nurses' salaries and amortize the loan. It would provide voluntary health insurance for the 10,000 people.

"The F.H.A. has had a very successful experience in insuring home loans, why not for the purpose of prvoiding health homes?" he asked.

### Deadly Serious

Kaiser said he was "deadly serious" in an effort to provide a public health measure that not only would encourage maximum initiative on the part of the medical profession but would also limit to a minimum any interference by Government agencies.

"The practice of preventive medicine is assured by providing the doctors with a regular income which compensates them for keeping their subscribers healthy rather than for treatment of illness," he wrote Senator Pepper.

"The prepaid medical plans made possible under the bill will operate as business enterprises, motivated by the impelling force of competition.

"This is not socialized medicine in the sense of a social experiment," he added. "The medical service rendered by the Permanente Foundation is fully equipped with the facilities required by the science of medicine and is wholly self-supporting and self-amortizing. This bill is a projection of that experience."

Kaiser said that since the bill provides a method for stabilizing and rationalizing the economics of medical practice, within the system of free private enterprise, he felt it should not meet objection from the medical profession.

He said he believed such a measure was necessary to provide group practice, with its various specialized forms, at low, regular cost to the subscribers. He cited that "prepayment relieves subscribers from financial inhibitions and encourages them to consult their doctors early and often."—Fred Duerr, in San Francisco *Chronicle*, July 19.

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## Governor Warren Signs Clinic Site Bill

First step in what is expected to develop into an important psychiatric institution in Los Angeles was taken on July 19, according to Dr. George Thompson, chief psychiatrist of General Hospital, when Gov. Warren in Sacramento signed a bill appropriating $100,000 to buy a site for a psychiatric clinic.

The clinic will be patterned after the Langley Porter Clinic established by the State three years ago in San Francisco.

There is no way to estimate the cost of the building and equipment but it probably will be in the neighborhood of $500,000.

The clinic will be devoted to research, teaching and treatment.

# COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

### San Francisco Group Plans Institution for Chronic Sick

San Francisco will have an institution for the care and treatment of the chronic sick, the first of its kind in this region, if present plans of the Federation of Jewish Charities here materialize.

The project is the outgrowth of studies indicating that sufferers from paralysis, arthritis, diabetes, heart disease and other ailments, lack adequate medical attention here, because of a shortage of specialized facilities in the community.

Under present plans, patients would receive all benefits of modern medical therapy for as long as necessary. The institution would serve free, part pay and full pay cases.

Conceived as a separate entity under the Federation of Jewish Charities, nevertheless it is expected that the Mt. Zion Hospital staff will furnish required medical care.... —San Francisco *Chronicle,* July 16.

### Los Angeles Blue Cross Plan

At least two and a half million Blue Cross members will receive more complete prepaid hospital care as the result of recent sweeping contract changes by nine Blue Cross plans....

Two geographically-opposite plans also recently revised their contracts to include more complete subscriber services—Wilkes-Barre, Pa., for the eleventh time in less than seven years and Los Angeles, Calif., for the third time in three years....

#### Third for Los Angeles

The third liberalization of benefits by the Blue Cross plan in Los Angeles means an extra 180 days of hospital care at 50 per cent discount in addition to the 21 provided annually for each illness or injury of separate cause. The first increase in subscriber benefits by this plan occurred about three years ago when all waiting periods for needed services were discontinued, and conditions existing at the time of joining were immediately covered for hospital service. The second liberalization came a year and half ago when the plan announced the inclusion of maternity benefits in all family contracts.—*"Blue Cross Bulletin,"* Vol. VIII, No. 6, June-July, 1945.

### Every Two Seconds a Patient Admitted to Hospitals

Americans entered hospitals as patients at the rate of one person about every two seconds last year, not counting the babies who were born in hospitals at the rate of one live baby every 16.4 seconds, the American Medical Association's 24th annual hospital census shows.

The 16,063,848 admissions to hospitals, exclusive of outpatients and newborn infants, is called "unprecedented" by Dr. F. H. Arestad and Dr. M. G. Westmoreland, in their report of the facts and figures on hospitals.

About one-fourth of these admissions, 4,287,271, were to federal hospitals and 2,257,949 to other governmental institutions.

The number of registered hospitals decreased to 6,611, which is 44 less than for 1943, but the number of beds increased to a total of 1,729,945.

In contrast to the feeling some patients may have had that they were being hustled out of the hospital pretty fast after an operation or the birth of a baby, to make room for the next patient, is the figure showing that in general hospitals the average length of stay per patient increased by one-half day.

Of the 1,919,976 babies born in hospitals last year, 96.7 per cent were born in general hospitals, with only 3.2 per cent born in maternity hospitals and 0.1 per cent in other institutions. The number of babies born in hospitals has more than tripled in the past 15 years.—San Francisco *News Letter,* May.

### Adult Respirators in California

Publication No. 24-C of The National Foundation for Infantile Paralysis, Inc., 120 Broadway, New York 5, N. Y., on "Respirators, Locations and Owners" was recently issued.

"The list of adult cabinet type respirators or 'Iron Lungs' has been compiled from records available May 1, 1945. It contains only those respirators which have been approved by the Council on Physical Medicine of the American Medical Association. The list is not complete for it does not give consideration to transfer and resale of machines, nor have all that are worn out been removed. These standard cabinet type respirators are not to be confused with other machines such as chest type respirators, resuscitators, inhalators or aspirators."

California is second in the States in the Union with number of standard respirators, the list in the five states having the largest number being as follows: New York, 159; California, 86; Pennsylvania, 81; Illinois, 59; Texas, 55.

The location list for California follows. Unless otherwise indicated, there is one (1) respirator. Counties follow names of cities, in parenthesis.

CALIFORNIA

| | |
|---|---|
| Arlington (*Riverside*) | Riverside County Hospital |
| Auburn (*Placer*) | DeWitt General Hospital (Owned by U. S. Army) |
| Bakersfield (*Kern*) | Kern County General Hospital ..... (3) |
| Berkeley (*Alameda*) | Berkeley Hospital |
| Carmel (*Monterey*) | Peninsula Community Hospital |
| Chico (*Butte*) | Fire Department |
| Daly City (*San Mateo*) | Villa Hospital |
| El Centro (*Imperial*) | Imperial County Farm and Hospital |
| Eureka (*Humboldt*) | Humboldt County Hospital |
| Fresno (*Fresno*) | General Hospital of Fresno County ..... (2) |
| Hanford (*Kings*) | Kings County Hospital |
| Hollister (*San Benito*) | Hollister City Hall |
| Lompoc (*Santa Barbara*) | Camp Cooke (Owned by U. S. Army) |
| Long Beach (*Los Angeles*) | Seaside Memorial Hospital |
| Los Angeles (*Los Angeles*) | Children's Hospital<br>Hospital of Good Samaritan<br>Los Angeles County General Hospital ..... (7)<br>(2 owned by Los Angeles County Chapter of the National Foundation) |
| Martinez (*Contra Costa*) | Contra Costa County Hospital |
| Marysville (*Yuba*) | Camp Beale (Owned by U. S. Army) |
| Modesto (*Stanislaus*) | Hammond General Hospital (Owned by U. S. Army) |
| Monterey (*Monterey*) | Fort Ord (Owned by U. S. Army)<br>Monterey Hospital |
| Oakland (*Alameda*) | Alameda County Hospital.. (2)<br>Children's Hospital of the East Bay |

| | |
|---|---|
| Orange (*Orange*) | Orange County Hospital |
| Palo Alto (*Santa Clara*) | Palo Alto Hospital |
| Pasadena (*Los Angeles*) | Collis P. & Howard Huntington Memorial Hospital<br>Pasadena Regional Hospital (Owned by U. S. Army) |
| Redding (*Shasta*) | Shasta County Hospital |
| Richmond (*Contra Costa*) | Permanente Field Hospital |
| Sacramento (*Sacramento*) | Sacramento County Hospital<br>Sutter General Hospital |
| Salinas (*Monterey*) | Monterey County Hospital |
| San Bernardino (*San Bernardino*) | The Argonauts Breakfast Club |
| San Diego (*San Diego*) | Mercy Hospital<br>San Diego County General Hospital .....(3) (1 owned by San Diego County Chapter of the National Foundation)<br>United States Naval Hospital .....(2) |
| San Francisco (*San Francisco*) | Children's Hospital .....(5)<br>French Hospital<br>Harbor Emergency Hospital<br>Isolation Hospital<br>Letterman General Hospital (Owned by U. S. Army)<br>Mission Emergency Hospital<br>Mount Zion Hospital<br>Park Emergency Hospital<br>San Francisco Hospital....(6)<br>Stanford University Hospital .....(2) (1 owned by San Francisco County Chapter of the National Foundation)<br>University of California Hospital .....(2) |
| San Jose (*Santa Clara*) | Santa Clara County Hospital .....**(2)** |
| San Mateo (*San Mateo*) | Mills Memorial Hospital<br>San Mateo Community Hospital |
| San Miguel (*San Luis Obispo*) | Camp Roberts (Owned by U. S. Army) |
| Santa Barbara (*Santa Barbara*) | Hoff General Hospital<br>St. Francis Hospital |
| Santa Cruz (*Santa Cruz*) | Mrs. W. N. Swazey |
| Santa Rosa (*Sonoma*) | Sonoma County Hospital...(2) |
| Stockton (*San Joaquin*) | San Joaquin County Hospital |
| Tulare (*Tulare*) | Tulare County General Hospital |
| Vallejo (*Solano*) | Vallejo Community Hospital |
| West Oakland (*Alameda*) | Permanente Foundation Hospital |

### Northwest Leads in Medical Insurance

The leading position of Washington and Oregon medical societies in prepayment plans for medical care was studied firsthand by the executive secretary of the American College of Radiology at a regional conference of the A.M.A. Council on Medical Service and Public Relations in Portland, April 7, 1945.

The secretary stated, in the Northwest, medical societies and hospital groups have controversies similiar to those in other sections of the country. But there the typical situation is reversed. Medical societies preceded hospitals in providing group hospitalization and medical service plans. They are now objecting to efforts by Blue Cross to move in.

The Kings County Medical Service Bureau, Seattle, has built its own hospital to provide hospitalization for the subscribers to its medical care plan. The Klamath Medical Service Bureau, Oregon, has done the same.

Doctors controlling the county society medical service bureaus in Washington and Oregon see no reason why they should surrender control of prepaid medical care to Blue Cross, so long as their present plans are adequately fulfilling local needs. With 14.2 per cent of its population covered by medical care insurance, Oregon leads all other states in percentage of population enrolled. Washington is second with 12.9 per cent covered .

Officers of Oregon Physicians Service charged that, "Despite denials to the contrary by Blue Cross authorities, there had been several definite instances of attempts made by hospital organizations or their representatives to intimidate, dominate, or control the medical profession or to subordinate the profession to hospitals or health centers."

### Five-Million-Dollar Expansion Planned for Letterman

*Letterman Hospital of San Francisco to Be Nation's Biggest Debarkation Unit*

A $5,000,000 expansion program for Letterman Hospital which will make it the largest debarkation hospital in the country was announced on July 27, by Brigadier General Charles C. Hillman, commanding officer of the hospital.

Headquarters of the Western Defense Command, now skirting the parade grounds, will be moved to Fort Winfield Scott.

The expansion program is expected to be completed within six months.

The Letterman Hospital reservation then will have 8,500 beds as compared with 3,100 at present.

Patients debarking from Pacific transports—both ships and planes—will stay at Letterman from five to six days before being transferred by train to hospitals nearest their homes—an average journey of 2,300 miles.

Twenty thousand patients can be handled monthly when the expansion is completed.

Fifty stucco buildings, containing 36 wards, two recreation centers, a theater, a chapel, a heating plant, and administration building, will be constructed along the bay on the old Crissey Field site.

All buildings will be connected by a central ramp.

A fishing pier will be built into the Bay for patients' use.

General Hillman said there would be a proportionate expansion of the hospital train unit.

There are now four tracks laid on Crissey Field to accommodate hospital trains. These will be connected with all parts of the hospital by covered ramp so patients may be wheeled from their beds directly to the train, eliminating the present ambulance trip.

In addition, a heavy shop for repair of hospital cars will be constructed at the far western end of the field.

Personnel of the hospital train unit will be increased to 3,000. Six thousand persons will be needed to operate the enlarged facilities. Fourteen hundred additional civilians will be required.

At present there are 1,200 enlisted men and 900 civilians employed. After expansion 3,000 soldiers and 2,000 civilians will be needed. The Letterman compound will house a total of 15,000—operating personnel and patients.

Dante Hospital at Van Ness Avenue and Broadway, now a Letterman annex, will be used solely for local admissions. The present Letterman Hospital will treat surgical and psycho-neurotic cases and the Crissey Field addition will handle all other cases.

Two large concrete buildings, now used as Western Defense Command headquarters, will be devoted to hospital beds. The brick buildings along the parade ground will be used as barracks for military personnel connected with the hospital. Increased number of casualties demand the expansion, General Hillman explained.*

In the first half of last year, he said, casualties from all theaters of war totaled only 9,000 a month. In May of this year alone, 57,000 wounded and ill men were debarked from fighting fronts—9,100 at San Francisco.

## Permanente Hospital in Oakland is Opened to Public

*Prepaid Medicine*

Henry J. Kaiser's Permanente Foundation Hospital in Oakland, built to provide prepaid medical care for 100,000 shipyard workers, has been opened to the public.

Clyde F. Diddle, administrator of the $2,000,000 hospital at Broadway and MacArthur Boulevard, said on July 20, that any individual may walk into the hospital and apply for complete, prepaid medical care.

Groups of 25 workers under one employer may also obtain medical service. The 300-bed hospital has 80 full-time physicians and surgeons, laboratories, clinics and pharmacies.

### Four-Point Plan

The Permanente Foundation, with hospitals at Oakland, Richmond, Fontana and Vancouver, operates under principles involving four points, Diddle said.

These are: pre-payment, group practice, adequate facilities, and "a new medical economy."

This "new economy," strongly opposed in part by some factions favoring the traditional family physician-patient relationship, follows the old Chinese practice of paying the physician while you are well.

"We offer medical service from nasal spray to surgery —and all under one roof," said Diddle. "The important thing is that there are no barriers to early treatment.

"There is a tendency, because of the cost of medical care, to let things go—to visit the doctor as little as possible and only when you are in desperate need.

"Those who believe in the new economy emphasize preventive medicine. Under the Foundation plan, patients are encouraged to come in early to shorten the treatment."

Diddle said the hospital, now released from the pressure of meeting the medical needs of some 50,000 shipyard workers who have left the yards in the past six months, has become the only hospital in the nation handling industrial accident cases on a contractural basis.

### Prepaid Care

Under this contractural system, the hospital receives a percentage of accident insurance premiums and provides, in return, care for the insurance company's clients' injured workers. It is another form of prepaid medical care.

"In another way, we are trying to continue the type of medical care Army and Navy men learned to expect in four years of war—the opportunity to drop in at a well-equipped, well-staffed hospital and receive treatment for anything from a scratched finger to a serious illness," Diddle explained.

It was disclosed on July 19 that Henry Kaiser was preparing a bill for introduction in Congress to permit establishment of voluntary systems for prepaid medical care throughout the country through the facilities of the Federal Housing Agency.

Diddle said that a 60-bed infirmary, named the Permanente Medical Center, was recently opened at Vallejo as an extension of the foundation's medical services.—San Francisco *Chronicle,* July 21.

* With unconditional surrender of Japan, new building plans for Letterman will be held in abeyance.

## Kaiser Widens Medical Plan

*Permanente System Extended in Vallejo*

Permanente Foundation, the Henry Kaiser prepaid medical plan, has been expanded to include a large group of persons not on company payrolls, with the extension of services to eight Vallejo area housing projects, it was revealed today.

The new medical center will be established in the wing of the present public health service infirmary. It will be open from 10 a.m. to 10 p.m., with service available at night on call.

A physician will be assigned to each dormitory.

This medical center has a potential membership of 25,000, according to company estimates.

The health plan expansion marks the beginning of efforts under way by the Kaiser organization to offer Permanente Foundation facilities to all groups interested in prepaid medicine.

A million and a half dollar addition made to the Permanente Hospital, Broadway and MacArthur Boulevard, Oakland, made the present extension possible, the company announced.—San Francisco *News,* July 17.

## Kaiser on Prepaid Medical Care

Henry J. Kaiser on July 20 called on San Francisco business leaders to approach reconversion in a spirit of boldness "uninfluenced by the rumors of depression, deflation, disorder or revolution."

He spoke to a Chamber of Commerce luncheon on "Post-War in Prospect," asserting that the West is in the van of great industrial development, that San Francisco faces the same challenge in peace that it did in 1906 after the fire. . . .

On the subject of prepaid medical care, he asked "Why can't we lead the way in providing the best in medical facilities to be within reach of all?

"Just across the bay we have a laboratory, or shall I say a model, which has been studied by medical authorities and public health officials from all over the nation and from a number of foreign countries.

"The confidence and commendation which has been expressed give us the faith to believe that this is a good idea. If only we could have at least one prepaid medical health center in every Western community, we could be assured that there really is to be a new world in which this priceless service becomes a right rather than a privilege." . . .—San Francisco *Chronicle,* July 20.

## Hospitalization of Communicable Diseases Los Angeles City—July, 1945

(COPY)

DEPARTMENT OF HEALTH
CITY OF LOS ANGELES

In accordance with Municipal Code of the City of Los Angeles (Sec. 32.12) which reads as follows:

". . . Before such isolation ward may be installed, operated or maintained, an application in writing therefor shall be made to the Board of Health and the approval by the Board of the installation, operation and maintenance of such isolation ward shall be first obtained. Such isolation ward shall be used exclusively for the

isolation, care and treatment of persons affected with such communicable or contagious diseases. Such isolation ward shall, at all times, be operated and maintained in conformity with the rules and regulations of the Board."

1. Because of their communcability, none of the following diseases may be cared for in any hospital, sanitarium, or other common place of care of persons except the Los Angeles County General Hospital which has been duly authorized, or in other contagious disease units which may be authorized in the future:

| | |
|---|---|
| Chickenpox | Pertussis |
| Cholera | Plague |
| Diphtheria (cases and carriers) | Poliomyelitis |
| German Measles | Psittacosis |
| Leprosy | Rabies |
| Leptospirosis (Weils Disease) | Typhus (Epidemic) |
| Measles | Smallpox |
| Meningococcic Meningitis | Scarlet Fever |
| Mumps | Tuberculosis (Infectious Stage)* |
| Paratyphoid Fever | Typhoid Fever |
| | Typhoid Carriers |

* Various institutions have been especially licensed to care for tuberculosis.

Note: Nothing herein is to be construed as demanding that any person with a communicable disease must go to the hospital. When hospitalization is necessary, however, only the Los Angeles County General Hospital is allowed to accept or keep such a patient. Any person infected with a communicable disease may remain at home, except in instances, when in the opinion of the Health Department, home conditions prevent isolation of the patient within the home.

2. Certain diseases because of their relative mildness or low communicability with the ordinary type of contact in institutions do not come under this classification, and therefore may be cared for in institutions using reasonable care to prevent their spread. These include:

| | |
|---|---|
| Actinomycosis | Malaria |
| Ascariasis | Mononucleosis (Infectious) |
| Chancroid | Pediculosis |
| Choriomeningitis | Pneumonia |
| Coccidiomycosis | a. Pneumococcal |
| Dengue | b. Other Bacteria |
| Dysentery (Amoebic) | c. Primary Atypical |
| (Bacillary) | Relapsing Fever |
| Encephalitis | Rheumatic Fever |
| Filariasis | Typhus (Endemic) |
| Food Infections (Salmonella) | Ringworm |
| Food Poisoning | Scabies |
| a. Staphylococcus | Streptococcal Infections |
| b. Botulism | a. Erysipelas |
| Gonorrhea | b. Pueperal Infections |
| Hookworm Disease | Syphilis |
| Infectious Hepatitis | Tetanus |
| (Catarrhal Jaundice) | Trachoma |
| Impetigo | Trichonosis |
| Influenza | Tuberculosis |
| Lymphogranuloma | (Non-infectious) |
| Venerium (Inguinali) | Tularemia |
| | Undulant Fever |

3. All institutional outbreaks including epidemic diarrhea of the newborn and impetigo must be reported to the Health Department immediately and will be handled according to the demands of the situation.

4. Exceptions to this policy must be authorized by the Health Department. For example, in exceptional cases where the movement of a patient with an acute communicable disease will jeopardize his life, the Health Department may authorize, temporarily, that he not be moved.

The above rules were adopted by the Board of Health Commissioners June 7, 1945, on recommendation of the Medical Committee of the Board.

## 17,500,000 Americans Now Members of Blue Cross

One out of every seven Americans, as of April 1, 1945, is paying his hospital bills in advance through non-profit Blue Cross plans serving 42 states, the District of Columbia, 7 Canadian provinces, and Puerto Rico. The 17,500,000 membership mark was passed as this year's first quarter growth of 1,000,000 persons broke all previous records.

Daily, 12,000 workers and family members, or 85,000 weekly, are adding their names to Blue Cross plan membership rolls as voluntarily-assumed protection against the unpredictable, and therefore burdensome, costs of hospitalized illness and injury. Coöperating are 350,000 employers who are either allowing payroll deduction or else paying part or all of the cost for employees.

The membership goal set for the close of this year by the 84 American Hospital Association approved Blue Cross plans across the nation is 21,000,000 persons, or a gain of 4½ million members during 1945. This gain would exceed by 1,000,000 the record growth of 1944.

### Three Plans Over One Million

Three Blue Cross plans report memberships of more than 1,000,000 persons: New York City, 1,950,000; Michigan, 1,243,950; and Massachusetts, 1,060,970. Eight additional plans report membership of more than 500,000 persons: Cleveland, 834,850; Chicago, 766,900; Pittsburgh, 753,700; Philadelphia, 722,000; New Jersey, 711,450; Minnesota, 617,200; St. Louis, 505,350; and Cincinnati, 501,960.

Only six states, containing but 5 per cent of the population of the United States, are now without hospital-sponsored Blue Cross plans. The four state-wide plans formed during the past year—Florida, Indiana, Utah, and Arizona—are spreading out rapidly to make protection available to the residents of these states.

### How They Join

Family dependents continue to exceed breadwinners in percentage of Blue Cross membership (54.8 and 45.2). Workers join for themselves and their families through their place of employment: industrial plants, factories, stores, offices, private and public institutions, professional groups, and farm and community organizations.

Twenty-nine Blue Cross plans now accept as members individuals who are self-employed, domestics, unemployed, or retired.

More than 425,000 hospital bills were paid by Blue Cross plans during the first three months of this year, the costs of which exceed $22,250,000. The daily admission rate for Blue Cross patients totaled more than 5,000. —*"Blue Cross Protection,"* Vol. 2, No. 1, Spring, 1945.

## Commission on Hospital Care

*A Non-Government Public Service Committee to Study Hospital Service in the United States*

*America's First Hospital Inventory—1945.*—For the first time in our history a complete inventory of our nation's hospitals is being taken. This inventory is part of a broad hospital study under the direction of the Commissioner on Hospital Care, 22 East Division Street, Chicago 10, Illinois.

Besides taking inventory of the 1945 hospital, the Commission on Hospital Care is analyzing economic, geographic and population factors—all of which have a direct bearing on postwar hospital construction and the future quantity and quality of hospital service throughout the country.

*The Commission on Hospital Care—What It Is.*—The Commission on Hospital Care is not an official public enterprise. It is not a private organization. It is neither —yet it is both.

The study is being conducted as a coöperative effort of government and voluntary hospital interests to discover the facts about the nation's hospitals.

The Commission was inaugurated by the American Hospital Association, is financed by funds from private resources and is sponsored by state and regional hospital organizations.

It is assisted in its work by the United States Public Health Service which has made technical personnel and physical facilities available to the staff. Also, state health departments have offered assistance and in some instances are actually conducting the studies.

*The Commission on Hospital Care—How and Why It Began.*—The unplanned growth and haphazard distribution of hospitals throughout the country is a situation which hospital people have been considering for a long time. Members of the American Hospital Association believed that complete inventory of all establishments offering bed care for the sick was basic to the planning and development of a coördinated hospital system.

They inaugurated a new organization, the Commission on Hospital Care. It is broadly representative of professional and public groups. It operates independently of any single organization. The Commission on Hospital Care is completely free from opinion and prejudice and is able to do the fact-finding job on a truly impartial basis.

Its members and its technical staff approach the problem with no preconceived plan. They are united and guided by a sincere interest in finding the facts. The study is financed by the W. K. Kellogg Foundation, The Commonwealth Fund, and The National Foundation for Infantile Paralysis.

*The Hospital—"Doctors' Workshop."*—A century ago the hospital was a dreary shelter for the destitute. Today it is the brisk, shining center of all society's life-giving and life-saving activities.

It was the lightning development of medical science that rocketed the hospital into this new position. Medicine's newer methods required the use of complicated machinery, expensive pilot study.

The Director of Study is A. C. Bachmeyer, M.D., and associated with him are Maurice J. Norby, Director of Research; Robert C. Morrey, M.D., Assistant Director, Surgeon (R) United States Public Health Service, and C. Horace Hamilton, Ph.D., Director of Sociological Research.

The roster of some 21 members of the Commission includes the names of two Californians:

Wilton L. Halverson, M.D., Sacramento; Director of Public Health, State of California; and

Herbert Hoover, Stanford University, California; Trustee, Stanford University [Stanford University Hospital].

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## "Blue Cross and the National Scene"*

The Blue Cross Plans for protection against the costs of hospitalized illness have enrolled more people in less time than any voluntary program in the history of the world.

This movement began as a cautious experiment in the law of averages. Ten years ago there were approximately 100,000 Americans budgeting their hospital bills through voluntary, non-profit prepayment plans which offered free choice of institutions. At the present time 18,000,000 persons—nearly one-seventh of our civilian population—are covered by Blue Cross Plans in 43 states and seven provinces.

Blue Cross protection is available in 3,500 member hospitals which constitute 85 per cent of the bed capacity open to the general public for acute illnesses. The movement is sponsored by 1,500 civic leaders from industry, labor, welfare, hospitals and the medical profession. These trustees serve without pay; their only reward is the satisfaction of performing a public service through which Americans can place hospital care in the family budget along with other necessities.

### From Experiment to Example

Blue Cross has now moved from the area of cautious experiment to the field of courageous leadership. Public acceptance has grown rapidly. In addition to the 18,000,000 members of Blue Cross Plans, an additional 8 or 10,000,000 receive more or less complete protection through industrial medical service and stock or mutual group insurance policies.

There are now 23 Blue Cross Plans coördinated with non-profit, medically sponsored prepayment programs for physicians' services. The number of such plans is increasing each month, and enrollment may ultimately reach the number of subscribers in hospital plans.

The coördination of medical plans with Blue Cross is consistent with the public's desire for protection against the full costs of hospitalized illness and with the elementary fact that medical attention and hospital care are interdependent factors in the diagnosis and treatment of illness.

The policies and methods of coöperation are in a formative stage, with different degree of administrative unity, which vary from completely identical to entirely separate corporations and personnel. The ultimate validity of any specific methods of coördination must be tested by public acceptance, quality of service, and the freedom of action and choice provided to physicians, institutions and patients. . . .

### Factors in Blue Cross Success

The Blue Cross method of furnishing health service is a product of two basic factors: *first,* the individual's "quest for certainty" in preserving and restoring his personal health; *second,* the community's recognition that sickness and accident are unpredictable by the individual, and hence require group action if health service is to be adequately distributed.

Health and hospital services are not a private commodity, whether considered from the point of view of available facilities, the general attitude of the public, or the history of the provision of hospital service.

The hospitals represent approximately $4,000,000,000 of capital investment. They have been constructed predominately from public funds, 95 per cent through voluntary philanthropic gifts or governmental taxes by local, state or national bodies. Adequate "stand-by" facilities are necessary to meet unpredictable health needs; hence entire communities have taken the leadership in providing them. Less than 5 per cent of the total hospital capital (2 per cent on the Atlantic Seaboard) has been provided by private investors who expected a return of, or interest on, their original investment. . . .

The public welfare demands that every individual be restored to reasonably good health as soon as possible. This basic factor underlay the practice of the sliding scale of fees when individual practitioners were the main source of medical knowledge and service; and it underlies the present custom throughout the world of permitting the entire population (with varying degrees of equity) full access to the publicly provided buildings, equipment and scientific apparatus in each community.

### The Approval Program

Twelve years ago the American Hospital Association recognized the value of the insurance principle for lightening the burdens of patients and stabilizing the income of hospitals. It is not the size, but the uncertainty, of

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* Excerpts from a paper by C. Rufus Rorem, Ph.D., C.P.A., Director Hospital Service Plan Commission, Chicago, Illinois, and presented at the Blue Cross Regional Conference, June 14-15, 1945, Philadelphia.

the hospital bill which makes it so burdensome for the person needing care. The uncertainty which makes it hard for the patient to pay his hospital bill also makes it difficult for hospital administrators and trustees to pay the bills of the institutions. Hospitals do not give service in order to get money; but they do need money in order to give service. The only question is: who shall pay the cost of hospital care and under what circumstances shall they do so?

The Association's approval of the insurance principle has been implemented by encouragement of hospitals to coöperate with prepayment plans; also guidance for community leaders in developing such plans by which the people could pay *their own hospital bills, with their own money, in their own institutions.*

A set of standards has been developed by the American Hospital Association which should characterize community-sponsored movements if the hospitals are to be urged to participate in them. These standards cover such points as non-profit organization, free choice of institution and doctor, reasonable charges to the public, adequate reimbursement of the hospitals, effective administration and control. Plans which meet these standards are permitted to identify themselves by a Blue Cross with the seal of the American Hospital Association superimposed upon it. Hence the name "Blue Cross Plan." The Blue Cross symbol was originated by Mr. E. A. van Steenwyk of Philadelphia, when he was administrator of the Minnesota Blue Cross Plan.

The Present Proposals and Prospects

Blue Cross success in reaching 18,000,000 Americans has brought a challenge to achieve protection for a much larger number of the employed population. At present eleven states have already enrolled 20 per cent or more of their total population. These include New York, New Jersey, Pennsylvania, Rhode Island, Delaware, District of Columbia, Connecticut, Ohio, Michigan, Minnesota and Colorado. In some metropolitan areas 50 to 65 per cent of the total population are enrolled under Blue Cross. There is need and opportunity for community leaders and the general population everywhere to do as well for themselves as other parts of our nation. . . .

# COMMITTEE ON POSTGRADUATE ACTIVITIES

## Public Health School on Berkeley Campus of U.C.

A graduate program will be inaugurated this fall in the school of public health on the Berkeley campus of the University of California under the direction of Dr. Walter H. Brown, acting dean.

A course in health education, leading to the degree of master of public health, will open the program. As the school develops, Dr. Brown says, it is planned to add graduate curricula in public health administration, epidemiology, sanitation, industrial hygiene, biostatistics, and public health laboratory.

"Since health education is one of the most rapidly expanding fields of public health and since the demand for competent persons to make the individual and the community intelligently aware of health problems is one of the most important public health needs, the University's school of public health is offering a graduate course in this field," Dr. Brown said.

Health educators work as regular members of health departments, or may be employed by schools or voluntary health agencies, the dean explained. Heading the new program on the Berkeley campus will be Dr. Clare E. Turner, visiting professor of public health education. The course will be given in coöperation with the school of education as persons thoroughly prepared in a diverse group of sciences and arts are required. Instructors will be drawn from the schools of education, public health and medicine.

## Wartime Graduate Medical Meetings

Note.—The C.M.A. Postgraduate Committee presents below the roster of speakers and topics of "Wartime Graduate Medical Meetings." These listings may have suggestive value to program committees of Component County Societies.

CLINICS, DEMONSTRATIONS, LECTURES

Under the Auspices of the American Medical Association, the American College of Physicians, the American College of Surgeons

Authorized by the Surgeons General, Norman T. Kirk, Ross T. McIntire, Thomas Parran

*Committee 24th Zone*

Lt. Comdr. Geo. C. Griffith (MC), USNR, Chairman
U. S. Naval Hospital, Corona
Capt. Harry P. Schenck (MC), USNR
Wayland A. Morrison, M.D.
James F. Churchill, M.D.

Program of the Wartime Graduate Medical meetings for Zone 24 (Southern California) follow:

*Birmingham General Hospital, Van Nuys, Calif.—3:00 p.m.*

Aug. 8—"The Management of Simple Skin Diseases."—Lt. Col. Everett R. Seale.

Aug. 22—"Anesthesia in War Surgery."—Lieut. L. E. Trotter.

*Camp Haan, A.S.F. Regional Hospital—3:30 p.m.*

Aug. 7—"Surgery of the Liver and its Ducts."—Capt. E. E. Larson.

*March Field, A.A.F. Regional Station Hospital—3:30 p.m.*

Aug. 21—"The Treatment of Burns and Their Plastic Repair."—Capt. Harold T. D. Kirkham.

*Camp Cooke Station Hospital—1:00 p.m.*

Aug. 1—"The Rh Factor."—Capt. George Macer.

Aug. 15—"Psychosomatic Medicine."—Dr. H. Douglas Eaton.

*Hoff General Hospital—8:00 p.m.*

Aug. 1—"The Rh Factor."—Capt. George Macer.

Aug. 15—"Psychosomatic Medicine."—Dr. H. Douglas Eaton.

*U. S. Naval Hospital, Santa Margarita Ranch—1:00 p.m.*

Aug. 9—"Some Dynamics of Military Neuro-psychiatry."—Major Alex. Blumstein.

Aug. 23—"Intra-ocular Foreign Bodies."—Lt. Comdr. H. Lusic.

*U. S. Naval Hospital, Long Beach—3:00 p.m.*

Aug. 15—"Problems in Obstetrics."—Comdr. Wood.

*U. S. Naval Hospital, Corona, Calif.—1:00 p.m.*

Aug. 9—"Pulmonary Tuberculosis."—Comdr. W. L. Rogers and Comdr. A. W. Hobby.

Aug. 23—"Penicillin in Syphilis and Gonococcic Infections"—Lt. Comdr. W. W. Duemling.

*U. S. Naval Air Training Station, San Diego—3:00 p.m.*

Aug. 3—"Plastic Repair of Lesions of the Face and Neck."—Dr. Edward S. Lamont.

Aug. 17—"Communicable Diseases."—Major Norman Nixon and Capt. Charles Marple.

*Santa Ana Army Air Base Regional and Convalescent Hospital—4:00 p.m.*

Aug. 7—"Peritoneoscopy."—Capt. J. C. Ruddock.
Aug. 21—"War Wounds of the Chest."—Lt. Comdr. J. P. O'Connor and Lt. Henry Jaffee.

*U. S. Naval Hospital, San Diego, Calif.—1:00 p.m.*

Aug. 2—"Clinical Aspects of Rheumatic Fever."—Lt. Comdr. Geo. C. Griffith.

# C.M.A. CANCER COMMISSION

### Federal Cancer Fund Favored

Princeton, N. J., July 20.—The American public would favor a Congressional appropriation of $200,000,000 for the study and treatment of the disease which ranks second only to heart trouble as a cause of death—cancer. Three out of four Americans say they are willing to pay more taxes to provide this money.

In 1942, 163,000 people died of cancer. To combat the disease the Cancer Society in its drive for funds succeeded in collecting aproximately $4,000,000 this year.

Survey by Institute

The American Institute of Public Opinion questioned men and women from coast to coast on the following issues:

Should Congress pass a law which would provide $200 000,000 for the study and treatment of cancer in this country?

The vote:

| | |
|---|---|
| Yes | 81% |
| No | 10% |
| No Opinion | 9% |

Would you be willing to pay more taxes to provide this money?

The vote:

| | |
|---|---|
| Yes | 75% |
| No | 20% |
| No Opinion | 5% |

—George Gallup in Los Angeles *Times*, July 21.

### Cancer Statistics

Harry S. Mustard, M.D., in a recent article stated:

By "Cancer" the public refers to all malignant tumors. Cancer is a public health responsibility because it affects relatively large numbers of people, because its frequency as a cause of death appears to be on the increase, because in some forms, in certain locations, and in particular stages, fatal extension is preventable, and because systematized social action seems necessary in approach to the problem.

One may obtain an idea of the trend of mortality in cancer and other malignant tumors by comparing death rates from these conditions, and from tuberculosis, over a period of years. In 1900 the tuberculosis death rate was more than three times that of cancer. The one has fallen and the other risen, so that the malignant disease death rate is now nearly three times as great as the death rate from tuberculosis.

Of the 158,335 deaths caused by cancer and other malignant tumors in the Registration Area of the United States in 1940, the digestive tract was the seat of the disease in about 50 per cent. In 10.6 per cent it was cancer of the uterus; cancer of the breast in 9.8 per cent. Cancer of the buccal cavity and pharynx was the seat of 3.2 per cent of all cancer deaths. Females are more frequently affected by malignant disease than are males. Of the 158,335 deaths from that cause in the U. S. Registration Area, in 1940, 75,406 were in males, and 82,929 in females. This excess proportion of deaths in females is largely incident to the greater frequency of carcinoma of the breast in that sex, and to the frequency of carcinoma of the uterus. Speaking in round numbers, it may be said that in the U. S. Registration Area in 1940, more than 15,000 females died of carcinoma of the breast, and less than 200 males. There were nearly 17,000 deaths from carcinoma of the uterus. Carcinoma of the buccal cavity, pharynx, and stomach are seen more frequently in males, and there were more than 12,000 deaths from carcinoma of the prostate and of the bladder in males in 1940.

The mortality rates in 1940, for cancer and other malignant tumors, are found to be 78.4 deaths per 100,000 population for Negroes, and 125 per 100,000 population for whites.

The Objectives in Cancer Control Programs are:

1. To teach the public to apply for early medical attention.
2. To influence the development of special cancer clinics, private and public, where there are ample provisions for diagnosis and treatment.
3. To influence the medical profession to make use of these special clinics in both diagnosis and treatment.
4. To encourage government and philanthropic support of institutes for cancer research, and to emphasize the need of experts in research.

# COMMITTEE ON INDUSTRIAL PRACTICE

### Inyo-Mono County Medical Society Acts on Revised Compensation Fee Schedule

On July 1, 1944, the Inyo-Mono County Medical Society adopted the fee schedule for Physicians and Surgeons for services rendered under Workmen's Compensation and Safety Laws, which schedule was presented to the Industrial Accident Commission of the State of California on December 30, 1942.

The following letter was sent to insurance companies:

Bishop, California, May 14, 1945.

Gentlemen:

On July 1, 1944, the members of this society put into effect a new fee schedule for all industrial accident cases. This is the fee schedule compiled by the C.M.A. in 1942 A printed copy was mailed to your office in May of 1942.

Enclosed is a compilation of the payments received by the physicians of this area from various insurance carriers since that time.

You will note that some of these carriers have paid all accounts in full. Your company has not.

The State Compensation Insurance Fund has paid over 57 per cent of its cases in full; in 23 per cent of cases it has underpaid; and in 20 per cent of its cases it has paid in excess of our bills as rendered.

Other companies, including your own, have a similar record, varying in percentages.

Therefore, at the April meeting of this medical society it was unanimously voted to notify all companies which have not been paying our bills in full, according to our fee schedule, that after June 1, 1945, all industrial accident cases will be accepted only at our schedule, and no other. The secretary of this society will expect to receive from you, previous to June 1, a written acceptance of this condition.

If such a letter is not on file in this office by June 1, 1945, it will be necessary to get telephone authorization from your office for care at our rates, in each case. Should this not be forthcoming, it will be necessary to hold the employer responsible for the costs of care. We sincerely hope you will not make this action necessary.

Yours sincerely,
WALTER WILSON, M.D.,
*Secretary,*
*Inyo-Mono County Medical Society.*

| | *Total Cases* | *In Full* | *Under-Paid* | *Over-Paid* | *Pending* |
|---|---|---|---|---|---|
| Calif. Comp. Ins. Co. | 93 | 61 | 32 | 0 | 0 |
| State Comp. Ins. Fund | 77 | 44 | 18 | 15 | 0 |
| Ind. Indemnity Exchange | 39 | 20 | 17 | 2 | 0 |
| Colonial Ins. Company | 21 | 10 | 10 | 0 | 1 |
| Nat. Automobile Ins. Co. | 20 | 6 | 13 | 0 | 1 |
| Maryland Casualty | 9 | 7 | 0 | 1 | 1 |
| Calif. Electric Co. | 10 | 8 | 0 | 0 | 2 |
| Travelers Ins. Co. | 7 | 1 | 6 | 0 | 0 |
| Pacific Employers Ins. Co. | 5 | 1 | 4 | 0 | 0 |
| Standard Accident Ins. Co. | 5 | 5 | 0 | 0 | 0 |
| Hartford Ins. Co. | 1 | 0 | 1 | 0 | 0 |
| Employers Mutual Liability Company of Wisconsin | 1 | 1 | 0 | 0 | 0 |
| Nevada Industrial | 1 | 1 | 0 | 0 | 0 |
| Fireman's Fund Indemnity | 3 | 1 | 1 | 0 | 1 |
| Great American Co. | 3 | 2 | 1 | 0 | 0 |
| City of Los Angeles | All cases in full | | | | |

Above are listed under each insurance company a compendium of industrial accident cases treated by the physicians of the Inyo-Mono County Medical Society from July, 1944, to May 1, 1945, under the new fee schedule. The total cases are given, number paid in full, underpaid, overpaid, a few cases payment pending.

### Health Hazards Improved in Certain Los Angeles Plants

Study of Los Angeles electroplating plants, initiated by the Division of Industrial Hygiene in April, has shown such remarkable improvement in conditions since a similar survey conducted in 1941, that the industry was given commendation for interest and coöperation in improving working conditions.

The earlier study had revealed at least one industrial health hazard in every plant, involving dusts, mists, gases, vapors, illumination, or sanitation. In the 15 plants visited by the end of April in the current study, these hazards had been eliminated. Chromium plating, cyanide plating, and trichlorethylene degreasing tanks were found to be equipped with adequate slot exhaust ventilation; all bright dip tanks were either exhaust ventilated or isolated in open sheds; buffing and polishing wheels were provided with exhaust ventilation; the majority of washing and toilet rooms met minimum sanitation requirements; and fluorescent fixtures had replaced many of the bare, unshaded incandescent bulbs.

### California to Study Tunnel Hazards

Exposure of railroad engineers and firemen to heat, gas, and fumes while traveling through tunnels is being investigated by the Bureau of Adult Health of the State of California Department of Public Health, in a cooperative study with the U. S. Bureau of Mines, the State Railroad Commission, and the State Industrial Accident Commission.

Because of the difficulty of obtaining reliable air samples and temperature measurements during the brief run of a locomotive through a tunnel, special methods have had to be devised for the study. A mobile chemical laboratory is to be shifted from point to point for the investigation. Gas samples collected by engineers in the locomotive cabs, and in the tunnels after trains have passed through, are to be analyzed immediately by the chemist.

Tests are to be made in 21 tunnels throughout the State, many of them having steep grades which make the heat, gas, and fume conditions complained of by trainmen more severe. For steam locomotives, measurements will include air temperature, relative humidity, air velocity, carbon dioxide and oxygen, carbon monoxide, sulfur dioxide, and smoke. In the case of diesel engines, temperature measurements will be omitted, but tests of nitrogen oxides will be made.

### Federal Safety Council Hears Health Plan

Accidents to Federal workers in 1944 cost the government approximately $18,000,000 in direct compensation, it was revealed by the U. S. Employees' Compensation Commission at the quarterly meeting of the Federal Interdepartmental Safety Council held in Washington June 8. Eight government employees were injured by unsafe handling of materials to every one hurt by explosions, fire, electrical burns, or other causes.

Necessity for a health program in the Federal service was explained by Dr. John W. Cronin, Chief of the U. S. Public Health Service Dispensary, who outlined a plan for such a program. Included in the health services recommended would be a preplacement physical and mental examination of every employee, with periodic reexamination. He proposed that a medical dispensary should be established in every Federal agency of sufficient size, where treatment could be given on the job for minor illnesses and injuries, and through which a broad program of health education could be carried on. Workers suffering from serious or chronic illnesses would be referred to their private physicians.

Accidental injuries showed a considerable decrease in 1944 from the level of previous years, the detailed report submitted to the Council by the U. S. Employees' Compensation Commission indicated. The average severity of injuries also was reduced.

### Rehabilitation of Handicapped Civilians Promoted

Attention of the nation was focussed upon the necessity of providing rehabilitation services for handicapped civilians as well as war veterans, with President Truman's proclamation designating June 2-9 as National Rehabilitation Week.

Employability of persons in the working age range who are handicapped by accident, disease, or congenital conditions is the goal of the program carried on by the Office of Vocational Rehabilitation, Federal Security Agency, in coöperation with the States.

About 1,500,000 men and women of working age are prevented from earning a normal livelihood by physical or mental handicaps, it was pointed out, and more are added by the annual toll of accidents and illness.

The Constitution, in all its provisions, looks to an indestructible Union composed of indestructible States.

—Salmon P. Chase, *Decision,* in Texas v. White, 7 Wallace, 725.

# CALIFORNIA PHYSICIANS' SERVICE†



We wish to give the California Medical Association the following progress report of California Physicians' Service from July, 1944, to July, 1945. This is not a detailed report, and the figures used are approximate. Listed below are the principal departments with a brief summary of their activities:

## Beneficiary Membership

MEMBERSHIP

| | *July, 1944* | *July, 1945* |
|---|---|---|
| Commercial Program | 78,843 | 149,000 |
| Housing Program | 17,006 | 11,500 |
| Rural Program | 1,184 | 2,000 |

INCOME

| | | |
|---|---|---|
| Commercial Program (monthly income) | $85,000 | $168,000 |
| Housing Program (monthly income) | 27,381 | 17,300 |
| Rural Program (monthly income) | 2,849 | 3,070 |

BENEFICIARY MEMBERSHIP

In the Commercial Program, our membership as well as the dues income has almost doubled during the last 12 months.

PROFESSIONAL RELATIONS

(a) In September, 1944, this Department was established in order to improve our relationship with professional members. Four persons were employed and trained to contact the doctors, their nurses, and secretaries. A C.P.S. "Information Kit" for doctors offices was prepared which contained a summary of benefits for beneficiary mmebers, a facsimile of membership cards, fee schedule, and other pertinent material. To date more than 2,000 doctors offices have been visited.

(b) We have supplied a C.P.S. speaker for many County Medical Society meetings. Medical Staff meetings in a number of the Metropolitan hospitals have been attended by our speakers.

(c) Articles are written and submitted to various County Medical Societies who issue monthly bulletins.

(d) Active drives for new professional members are handled by our Professional Relations Department. Over 300 new doctors have joined during the last year. To date C.P.S. has 5,600 professional members. We have found that this department is doing a great deal to perfect our working relationship with professional members.

PUBLIC RELATIONS

This Department was organized in March, 1945, and has four trained speakers. Its purpose is to inform the business men of the State on Voluntary Health coverage as offered by the doctors and hospitals. To date 97 talks have been given to service groups such as, Rotary, Kiwanis, Lions, Chamber of Commerce, Optimists, and various women's clubs. Approximately 3,840 business men and women have heard our speakers. Endorsements from the Chamber of Commerce, Merchants and Manufacturers, Downtown Business Men's Associations and other such organizations have been due to the efforts of this department. The primary functions of our Public Relations is to produce leads for the Sales Department. The speakers reports show that only 5 per cent of the audiences have ever heard of the doctors and hospital service. Many new groups are now being written by our Sales Department through the work of Public Relations.

HOUSING PROGRAM

The C.P.S. War Housing projects are disintegrating. As you know these were to be temporary, and it seems that their purpose is almost at an end. We are closing the two medical centers in Long Beach, namely: Wilmington Hall and Channel Heights on July 15 and August 1, 1945. This leaves only two C.P.S. Housing Projects in the State, Vallejo and Marin City. Our project in Marin City is rapidly being taken over by evacuees from the Orient and Army and Navy personnel. It cannot last very long. Vallejo is still an acute area, and the Housing Project Medical Centers will remain for some time due to a request by the Solano County Medical Society.

FARM SECURITY PROGRAM

C.P.S. has rendered care to some 2,000 low income farm families. This program was carried on in conjunction with the Farm Security Administration. The doctors were paid a unit value of $1.50. We are now negotiating with the California State Grange, which has a membership of about 25,000 farmers—with dependents this represents about 80,000 persons. Our Two-visit Deductible and Surgical service is being offered. If the Grange or any other large farm group accept our service we will then liquidate the old Farm Security Plan, and place all coverage under our Commercial Program.

RATE INCREASE

C.P.S. has had a long hard struggle in returning a reasonable fee to its professional members. Much ill-will has been caused because of a low unit value. From an all-time low unit of $1.20 three years ago, C.P.S. has gradually corrected certain functions, and during the last 15 months has paid a unit value of $2.25, which is 90 per cent of the par, $2.50. In order that we could reach par and at the same time broaden out benefits to beneficiary members, the Trustees voted a rate increase of approximately 30 per cent to beneficiary members the first part of December, 1944. Due to objections by the Hospital Association this was held up until April of 1945. However, the rate of increase is 95 per cent completed, and we have lost less than ¼ of 1 per cent membership due to this rate increase.

REVISION OF ADMINISTRATION

Since the May meeting of the House of Delegates C.P.S. has been undergoing certain changes in its administration. New personnel for key positions are being brought in, two from out of the State, and several from within the State. Some of our older personnel are being placed in positions for which they are better fitted. Office procedures and functions are being revised and streamlined.

This report lists most of the principle functions of C.P.S. Although some of these have been in operation

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161.
Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization through W. M. Bowman, Executive Director.

only a short time the results have convinced me that they will add to the growth and efficiency of C.P.S. I am not over-optimistic in predicting that C.P.S. will double and probably triple its present beneficiary membership during the next 12 to 14 months. Responsibility for much of our success and development continues to rest with our professional members, for it is they who are rendering the service.

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**California Coördinating Committee—Re: C.P.S.**

(COPY)

WAR MANPOWER COMMISSION
PROCUREMENT AND ASSIGNMENT SERVICE
For Physicians

San Francisco, July 5, 1945.

Philip K. Gilman, M.D.,
Chairman of the Council,
California Medical Association.

Dear Doctor Gilman:

I am enclosing herewith a copy of a letter to the Board of Trustees of the California Physicians' Service which I was directed to write by the members of the Coordinating Committee, Procurement and Assignment Service, at their last meeting. I realize that without the backing of the Executive Committee and the Council of the California Medical Association that the California Physicians' Service would have been unable to carry on these programs as it has. It was, therefore, the consensus of the Coördinating Committee that I should again express its appreciation to the Council of the C.M.A. for its backing and coöperation during this emergency.

With my kindest regards, I remain,

Sincerely yours,

(Signed) HAROLD A. FLETCHER, M.D.,
*California State Chairman for Physicians Procurement and Assignment Service.*

* * *

(COPY)

WAR MANPOWER COMMISSION
PROCUREMENT AND ASSIGNMENT SERVICE
For Physicians

San Francisco, July 5, 1945.

Lowell Goin, M.D.,
Chairman of the Board of Trustees,
California Physicians' Service,
1930 Wilshire Boulevard,
Los Angeles, California
and
Chester L. Cooley, M.D.,
Secretary, Board of Trustees,
California Physicians' Service,
490 Post Street,
San Francisco, California.

Gentlemen:

At the regular meeting of the Coördinating Committee of the Procurement and Assignment Service of June 5, 1945, I am instructed to write a letter to the Board of Trustees of the California Physicians' Service expressing the appreciation of the Coördinating Committee of Procurement and Assignment Service for the real aid and contribution to the war effort which has been made by the California Physicians' Service. With the tremendous needs of the military forces for medical personnel and with the tremendous expansion in population in certain localities in California antedating and following the Pearl Harbor attack, there were many problems of medical care which the Procurement and Assignment Service was called upon to solve. One of the greatest problems, of course, was medical coverage in many of the housing projects in critical areas where the population mushroomed to a tremendous size without any previously worked out plan for medical care. The Procurement and Assignment Service was faced with several alternatives at different times, many of which would have been dangerous to the future of the medical profession.

California was fortunate in having an organization in the California Physicians' Service, backed by the medical profession, which could, during the emergency, expand its activities to cover these emergency needs. Had not the California Physicians' Service willingly and patriotically coöperated with the war effort, the critical needs would not have been met; or if they had been met, it would have been through means which would probably have jeopardized the future of many physicians patriotically serving their country in the military forces, and would have undoubtedly undermined the freedom of the practice of medicine in California. Although the California Physicians' Service was not set up to undertake this type of medical coverage, with the backing of the California Medical Association it was able to meet the needs when called upon to do so. The Coördinating Committee has appreciated the coöperation of both the California Medical Association and the California Physicians' Service which it has had at all times. The work of the California Physicians' Service in meeting emergency needs in housing projects and expansion areas has been outstanding and has entailed a tremendous amount of organizational and executive work. At times it has had to fight organized resistance to it on the part of extreme leftis organizations as well as, unfortunately at times, resistance on the part of the medical profession. It is to be noted, however, that in practically all those cases where the medical profession coöperated the program in the housing projects has been successful both from the standpoint of the patient as well as the local physician.

It is the opinion of the Coördinating Committee that, in spite of many complicated and varying difficulties under which it had to work, the California Physicians' Service has contributed an outstanding service to the war effort in California.

Yours very truly,

(Signed) HAROLD A. FLETCHER,
*Chairman, Coördinating Committee on Medical Care,*
*Procurement and Assignment Service.*

P.S.—For your information, I am appending a full list of the membership of the Coördinating Committee of Procurement and Assignment Service.*

H.A.F.

* * *

*Membership of the Coördinating Committee of Procurement and Assignment Service*

*Harold A. Fletcher, M.D.,* Chairman, Room 1331, 450 Sutter Street, San Francisco 8, California.

*George E. Ebright, M.D.,* Vice-Chairman, 384 Post Street, San Francisco, California.

*Mr. John Hunton,* Secretary, Room 2004, 450 Sutter Street, San Francisco 8, California.

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(*Ed. Note.—In the Harbor Area of Los Angeles, C.P.S. rendered notable service in housing projects at Wilmington, Banning Homes and Channel Heights. So also in housing projects in the San Francisco Bay area. At the Richmond Center, California Medical Association coöperated with C.P.S. by subsidizing the medical center to a total of $6,266.30, as noted in June CALIFORNIA AND WESTERN MEDICINE, on page 346, under item 8.)

*Colonel W. T. Harrison*, Regional Medical Director, U. S. Public Health Service, Appraisers' Building, San Francisco, California.

*Wilton Halverson, M.D.*, Director, State Dept. of Public Health, 760 Market Street, San Francisco, California.

*Morton Gibbons, Sr., M.D.*, Chief Emergency Medical Service, State War Council, 411 Phelan Building, 760 Market Street, San Francisco, California.

*Ernest Sloman, D.D.S.*, Dental Chairman, Ninth Corps Area, Procurement and Assignment Service, 344 14th Street, San Francisco, California.

*John W. Leggett, D.D.S.*, California State Chairman for Dentists for Northern California, 490 Post Street, San Francisco, California.

*Albert E. Larsen, M.D.*, Medical Director, California Physicians' Service, 153 Kearny Street, San Francisco, California

*Karl L. Schaupp, M.D.*, Ninth Corps Area Chairman, Procurement and Assignment Service, 490 Post Street, San Francisco, California.

*Anthony J. J. Rourke, M.D.*, Superintendent, Stanford Hospital, Clay and Webster Streets, San Francisco, California.

*L. R. Chandler, M.D.*, Dean, Stanford University Medical School, Clay and Webster Streets, San Francisco, California

*William P. Shepard, M.D.*, Medical Director, Metropolitan Life Insurance Company, 600 Stockton Street, San Francisco, California.

*Mr. Thomas Clark*, Executive Officer, Association of California and Western Hospitals, 1182 Market Street, San Francisco, California.

*Miss Marian Alford, R.N.*, Chairman, Procurement and Assignment Service for Nurses, 26 O'Farrell Street, San Francisco, California.

*Mrs. M. E. Schmidt, R.N.*, Nurse Deputy to Chief of Emergency Medical Service, State War Council, 411 Phelan Building, 760 Market Street, San Francisco, California.

# COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

### Commonwealth Club of San Francisco Votes on Sickness Insurance Plans

By a two to one vote, Commonwealth Club of California members have indorsed voluntary health insurance, a tally revealed in July. Members expressed their opposition to compulsory plans in another ballot, however, it was announced.

Voting followed study of the question by the club's public health section.

Club officers said that, while opposing compulsion, the majority held that if a compulsory plan were adopted, the "free system" of paying doctor bills would be preferable to the "per capita system." The majority also held that if a compulsory plan were adopted, Governor Warren's bill in the recent legislative session would be preferable to the C.I.O. bill.

Members favored State regulation of voluntary health plans as to character and solvency, premiums charged and extent and quality of services. They opposed State financial assistance to voluntary plans, but favored educational assistance and legal status clarification.

Complete results follow:

I. (a) Should California encourage voluntary enrollment of its citizens in various private prepayment health plans? (Yes 859, No 248)
(b) Should it be done now? (Yes 776, No 175)

II. (a) Should California establish some compulsory prepayment health insurance system? (Yes 451, No. 741)
(b) Should it be done now? (Yes 406, No 549)

III. If, regardless of your opinion above, some such system is to be established, which is preferable:
(a) Voluntary? (833) OR
(b) Compulsory? (403)

IV. If any compulsory system is established which of the following general proposals should be adopted:
(a) Adoption of a compulsory insurance plan in which citizens who are employees will prepay for doctor, surgical, and hospital services through automatic deductions from salaries or wages as a payroll tax? (907)
(b) Direct public support of all health services through other taxation? (241)

V. If "I" above were adopted should the State assume regulatory powers over private prepayment health plans as to:
(a) Character and solvency of any organization offering a prepayment health service? (Yes 1072, No 117)
(b) Premiums charged? (Yes 866, No 301)
(c) Extent and quality of services to be rendered? (Yes 884, No 280)

VI. If "I" above were adopted, should the State encourage voluntary prepayment health plans by:
(a) Rendering financial assistance? (Yes 336, No 788)
(b) Clarifying legal status? (Yes 921, No 197)
(c) Giving educational assistance? (Yes 918, No 224)

VII. If "II" above were adopted, should the physician be paid:
(a) Per unit of services he renders (i.e., "fee system")? (906)
(b) Per patient enrolled with him (i.e., "capitation system")? (240)

VIII. If "II" were adopted, should provision be made in it for health service for the indigent? (Yes 853, No 279)

IX. If "IV-a" were to be adopted, should the cost be borne:
(a) By payments entirely from the employee? (359)
(b) By joint payments from both employee and the employer? (329)
(c) By joint payments from the employee, the employer, and the State? (480)

X. If "IV-a" above were adopted
(a) Should the plan require an employee to pay in full or in part for the first visit to a physician in any illness? (Yes 85, No 340)
(b) Should limitations be placed upon
(1) Length of time during which a physician's service would be available for an illness? (Yes 415, No 629)
(2) Length of hospitalization for an illness? (Yes 429, No 558)
(c) Should the employee be required to pay the first $50 of bills for illnesses in any one year and the Fund pay all further medical and hospital bills? (Yes 502, No 512)

XI. If compulsory health insurance is established, should the State encourage private groups to provide service under the Act? (Yes 808, No 205)

XII. Of following proposed plans recently before the Legislature, which do you consider satisfactory?
(a) Assembly bill 800 (Gov. Warren's bill)? (Yes 405, No 384*)
(b) Assembly bill 449 (C.I.O. bill)? (Yes 141, No 504†)
(c) Assembly bill 1200 (Calif. Med. Assn. bill)? (Yes 403, No 370‡)
(d) Senate bill 219 (Farm Bureau bill)? (Yes 99, No 526§)

XIII. If either of the COMPULSORY health insurance proposals recently before the Legislature were to be adopted, would you prefer:
(a) Assembly bill 800 (Gov. Warren's bill)? (809)
(b) Assembly bill 449 (C.I.O. bill)? (124)

XIV. Do you favor a compulsory plan for hospital care alone? (Yes 182, No 890)

XV. Do you think the present Legislature should study the question of health measures through an interim committee until the next session? (Yes 814, No 270)

XVI. Should the present Legislature refer the general question of compulsory health insurance to a popular vote? (Yes 510, No 594)

* 469 did not answer. † 613 did not answer. ‡ 485 did not answer. § 633 did not answer.

Why forego the advantages of so peculiar a situation? Why quit our own to stand upon foreign ground? Why, by interweaving our destiny with that of any part of Europe, entangle our peace and prosperity in the toils of European ambition, rivalship, interest, humor or caprice?

—George Washington, *Farewell Address*, 17 September, 1796.